

Office of Developmental Services Request for Reimbursement of Support Coordination

Please submit this form once the individual has transitioned from the training center, along with copies of support coordination notes for the months for which you are billing, to:

Lee Price, Director of the Office of Developmental Services, 804-692-0077 (FAX)

Name of individual transitioning from a Tr	raining Center:
Training Center at which he/she formerly i	resided:
Date of initial contact by the Support Coor	dinator related to this transition:
First date that the community residential p	rovider is eligible to bill Medicaid:
beginning with the date of the initial contact departed the training center. NOTE : do no billed to Medicaid Targeted Case Manager	ent is being sought (maximum of 5 months permitted, ct regarding transition to the date the individual at request reimbursement for any month which may be ment [TCM], i.e., TCM may be billed once the d also for the 30 days immediately prior to discharge):
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Number of months	Total reimbursement sought
Signature of ID Director	Date